1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3681

CERTIFICATE OF DEATH

03673

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x/14 EAST-DELMAR
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: IONA Middle: Last: Baker

4. DATE OF DEATH: Month: March Day: 12 Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 10-8-1892

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN W. BYRD

14. MOTHER'S MAIDEN NAME: ELIZABETH BYRD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-16-4918

INFORMANT: Cecil Knight Address: Hallwood Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-12, 19 59 to 3-12, 19 59 that I last saw the deceased alive on 3-12, 19 59, and that death occurred at 7:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilm R. Cobb M.D. ADDRESS (Street, city or town, state): Salisbury, Md. DATE SIGNED: 3-13-59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-15-59

22c. NAME OF CEMETERY OR CREMATORY: Byrd Cemetery

22d. LOCATION (City, town, or county) (State): Hallwood, Va

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W. S. Mapp Co. Melmar, Va

24a. REC'D BY REGISTRAR DATE: MAR 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kimmey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03674

3682 -Item 9 FilmG240 3-30-59 et

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne — 19X-2
d. STREET ADDRESS: Hampton Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

82

3. NAME OF DECEASED (Type or print): First Charles — Middle William — Last Ballard
4. DATE OF DEATH: Month 3 — Day 18 — Year 1959
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/19/~~99~~ 1919
9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LCBAR
10b. KIND OF BUSINESS OR INDUSTRY: FUNERAL HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: CHARLES BALLARD
14. MOTHER'S MAIDEN NAME: MAGIE MORRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: MAGIE BALLARD PRINCESS ANNE, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hemorrhage	25 min.
DUE TO (b)	Stab wound of ascending aorta	25 min.
DUE TO (c)		

982 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed by brother during a fight.
20c. TIME OF INJURY — Hour: 5:20 o.m. P.M. — Month, Day, Year: 3-18-59
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Beer Tavern.
20f. (City or town): Princess Anne (County): Somerset (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

2

ACTUAL SIGNATURE: Earl L Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-23-59
EXAMINER'S NAME (Type): Earl L. Royer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/23/59
22c. NAME OF CEMETERY OR CREMATORY: John Wesley
22d. LOCATION (City, town, or county) (State): Princess Anne, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: WILLIAM H. JAMES JR. PRINCESS ANNE, MD
24a. REC'D BY REGISTRAR — DATE: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Oakley S. Knott

WP

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03675
Reg. Dist. No. 3683

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen Gen Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury
d. STREET ADDRESS 119 A. South Division St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle FRANKLIN Last BAYSINGER
4. DATE OF DEATH: Month MARCH Day 14th Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Jan. 4, 1905
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Medina Ohio
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Frank W. Baysinger
14. MOTHER'S MAIDEN NAME: Alice C. Haun

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.#II
16. SOCIAL SECURITY NO.: 220-09-9889
17. INFORMANT (Address): Mr. Melvin Disharoon (Nephew-Trustee) 304 Park Heights Ave. Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b): 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Earl L. Royer M.D.
EXAMINER'S NAME (Type) Dr. Earl L. Royer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED March 16 /1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 17, 1959
22c. NAME OF CEMETERY OR CREMATORY: Buckingham Cemetery
22d. LOCATION (City, town, or county) (State): Berlin, Marylamd

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE MAR 17 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3684 — Reg. Dist. No. 03676

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 SALISBURY
d. STREET ADDRESS: 1422 FRANKLIN AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WOODIE — Middle CARROLL — Last BOZMAN

4. DATE OF DEATH: Month MARCH — Day 17 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 10, 1888

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Salesman(Furnature)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Dames Quarter Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Wesley Bozman

14. MOTHER'S MAIDEN NAME: Ellen Rebecca Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
If yes, give war or dates of service: W.W.I(One)

16. SOCIAL SECURITY NO.:

INFORMANT (Address): Mrs. Florence S. Bozman (Wife) 422 Franklin Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-17, 19 59 to 3-17, 19 59 that I last saw the deceased alive on 3-17, 19 59, and that death occurred at 6:50 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilber R. Ellis Jr M.D. — ADDRESS (Street, city or town, state): Salisbury, Md — DATE SIGNED: 3-17-59

PHYSICIAN'S NAME (Type): Dr.Wilber R.Ellis Jr — Medical Center - Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar.20,1959
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: MAR 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03677

3685 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 37 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pittsville
d. STREET ADDRESS: R.D.# 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Bertha; Middle: L.; Last: Bradford

4. DATE OF DEATH: Month: March; Day: 5; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 16, 1886

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland (Worcester Co.)

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Isiah Powell

14. MOTHER'S MAIDEN NAME: Sarah Timmons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address: Mrs. Ronnie Kelly Mumford (Daughter) R.D.#1 ~~Pittsville, Maryland~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (b):
DUE TO (c):
443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Obesity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 27, 1959, to March 5, 1959, that I last saw the deceased alive on March 5, 1959, and that death occurred at 2:20P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldve, M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 3/5/59

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 8, 1959
22c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
22d. LOCATION (City, town, or county) (State): Worcester Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: MAR 10 '59

24b. REGISTRAR'S SIGNATURE: C. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03678

3686 Item 8 Fil-0241 +-7-5) et

Reg. Dist. No.

1. PLACE OF DEATH ■ COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a STATE: Delaware
b COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Selbyville
d STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First Donnis — Middle — Last Brasure
4. DATE OF DEATH: Month 3 — Day 19 — Year 59

5. SEX: M
6 COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 4 1959
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months — Days 14
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): DELAWARE
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William J. Brasure
14. MOTHER'S MAIDEN NAME: Ethel Cadmo

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO:
17. INFORMANT: Address: William J. Brasure Selbyville Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
125 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-19-59
EXAMINER'S NAME (Type): Earl L. Royer, M.D.

22a. BURIAL CREMATION REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/21/59
22c NAME OF CEMETERY OR CREMATORY: Rizna
22d LOCATION (City, town, or county) (State): Fairfield Cemetery

23 FUNERAL DIRECTOR'S SIGNATURE: Hudson & Hearn Funeral Home
ADDRESS:
24a REC'D BY REGISTRAR DATE: APR 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Hearn

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3744

CERTIFICATE OF DEATH

0367

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First: Alvin — Middle: T. — Last: Bratten

4. DATE OF DEATH: Month: March — Day: 10 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Aug 10, 1883

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: own farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William B Bratten

14. MOTHER'S MAIDEN NAME: Martha J. Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 216-14-9607

17. INFORMANT: Kate Bratten — Address: Willards Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Dilated Heart — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Chronic Brights — Oct 1958
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

593X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1958 to Mar 10 1959, that I last saw the deceased alive on Mar 5 1959, and that death occurred at 1 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas. R. Dew M.D. — ADDRESS (Street, city or town, state): Berlin Md — DATE SIGNED: 3-10-59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-13-59

22c. NAME OF CEMETERY OR CREMATORY: Bratten Family Cem.

22d. LOCATION (City, town, or county) (State): Willards, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Wesley — ADDRESS: Selbyville Del.

24a. REC'D BY REGISTRAR DATE: MAR 11 '59

24b. REGISTRAR'S SIGNATURE: Arthur S Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03680

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND — 3667
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 8 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POCOMOKE CITY
d. STREET ADDRESS: 34 GREENWAY AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VIANNA — Middle B. — Last Byrd.
4. DATE OF DEATH: Month March — Day 28 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 7, 1931
9. AGE (In years last birthday): 27 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BEAUTICIAN
10b. KIND OF BUSINESS OR INDUSTRY: BEAUTY SHOP
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: STANLEY BACALL
14. MOTHER'S MAIDEN NAME: VIANNA TATMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO.
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 218-24-4994
INFORMANT: C. AMES BYRD, Address: POCOMOKE CITY, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Subdural Hematoma secondary to (c) (Non-Traumatic) — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO (b): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Acute Monocytic Leukemia — 8 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/20, 1959, to 3/28, 1959, that I last saw the deceased alive on 3/28, 1959, and that death occurred at 1.25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Rufus S. Gardner, Jr. M.D — ADDRESS (Street, city or town, state): PINEbluff Rd. — DATE SIGNED: 3/28/59
PHYSICIAN'S NAME (Type): RUFUS S. GARDNER, JR. — SALISBURY, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-31-59
22c. NAME OF CEMETERY OR CREMATORY: SALEM METHODIST
22d. LOCATION (City, town, or county) (State): POCOMOKE CITY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson — ADDRESS: POCOMOKE CITY, MD.
24a. RECEIVED BY REGISTRAR — DATE: APR 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3688 **CERTIFICATE OF DEATH** 0368

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Maryland
c. LENGTH OF STAY IN 1b: 1 mo. 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: 9 Maryland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie; Middle: CHAIRES; Last: Calder

4. DATE OF DEATH: Month: March; Day: 14; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/26/1892

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unk

10b. KIND OF BUSINESS OR INDUSTRY: unk

11. BIRTHPLACE (State or foreign country): Showell, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John M. Ryan

14. MOTHER'S MAIDEN NAME: Ana Daisey Campbell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unk
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unk

17. INFORMANT: Hospital Records, Salisbury, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis with left hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 3 months
332X
DUE TO
(b): Arteriosclerosis, general — unk.
DUE TO
(c): [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month / Day / Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 12, 19 59, to March 14, 19 59, that I last saw the deceased alive on March 13, 19 59, and that death occurred at 1:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Kosmahly M.D
ADDRESS (Street, city or town, state): Salisbury, Md.
DATE SIGNED: 3/14/59

PHYSICIAN'S NAME (Type): Gerhard Kosmahly, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/16/59
22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN
22d. LOCATION (City, town, or county): BERLIN (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna B Burbage
ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: MAR 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained with your files.

TO FUNERAL DIRECTOR: Page 3 should be used for burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A13ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03682

Reg. Dist No. 3689

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: R F D # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edgar — Middle: S — Last: Carmean
4. DATE OF DEATH: Month: 3 — Day: 21 — Year: 19 59
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-22-1875
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Snow Hill Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Willard S. Carmean
14. MOTHER'S MAIDEN NAME: Lucella Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs Clifford Duffy, 2671 Snow Hill Road — Address: Salisbury, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Arterio-sclerotic cardio-vascular disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

INTERVAL BETWEEN ONSET AND DEATH: days / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fractured right hip.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Fell in own home.
20c. TIME OF INJURY: Hour: P.M. — Month, Day, Year: 3-13-59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Own home
20f. (City or town) Snow Hill (County) Worcester (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-23-59

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: March 24/59
22c. NAME OF CEMETERY OR CREMATORY: Bates Methodist Cemetery
22d. LOCATION (City, town, or county) Snow Hill (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE: Elay & Timms
ADDRESS: Snow Hill Md
24c. REC'D BY REGISTRAR DATE: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3745

CERTIFICATE OF DEATH

Reg. Dist. No. 03683

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Nanticoke
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA — Middle S. — Last CONWAY

4. DATE OF DEATH: Month Mar. — Day 26 — Year 1959

5. SEX: Female — 6. COLOR OR RACE: Negro — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 6/5/1881 — 9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months 9, Days 21 — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife — 10b. KIND OF BUSINESS OR INDUSTRY: Own Home — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James R. Hayward — 14. MOTHER'S MAIDEN NAME: Alice Cotman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): — — — — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Mrs Julius Wallace — Address: Nanticoke, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Uteris. — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO (b)
DUE TO (c)
174X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Insanity. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/3, 1958 to 3/26, 1959, that I last saw the deceased alive on 3/26, 1959, and that death occurred at 3 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard H. Saunders M.D. — ADDRESS (Street, city or town, state): Nanticoke Md. — DATE SIGNED: 3/28/59

PHYSICIAN'S NAME (Type): Richard H. Saunders — Nanticoke, Maryland — 3/2./59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 3/29/59 — 22c. NAME OF CEMETERY OR CREMATORY: New Town Cem. — 22d. LOCATION (City, town, or county) (State): Pyaskin, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. T. Messick — ADDRESS: Bivalve, Maryland — 24a. REC'D BY REGISTRAR DATE MAR 31 '59 — 24b. REGISTRAR'S SIGNATURE: Catherine I. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03684

3690

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 403 Dover St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James; Middle: Love; Last: Cooper

4. DATE OF DEATH: Month: 3; Day: 17; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/17/1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months; Days; Hours: 1; Min: 55

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never Work

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: B. Randolph Cooper

14. MOTHER'S MAIDEN NAME: Annabelle Love

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mr. Randolph Cooper, Sone — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fetal type atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs

DUE TO (b): Prematurity with marked immaturity (Wt 3109 grms.)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 15, 1959 to Mar 17, 1959 that I last saw the deceased alive on Mar 17, 1959, and that death occurred at 10:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H B Saunderson Jr M.D.

ADDRESS (Street, city or town, state): 702 Camden Avenue

DATE SIGNED

PHYSICIAN'S NAME (Type): Robert W. Saunderson, Jr., M.D. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/18/59

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

22d. LOCATION (City, town or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hill & Johnson Co. Salisbury — ADDRESS

24a. REC'D BY REGISTRAR DATE: MAR 20 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

Norman T. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3691 — Reg. Dist. No. 03685

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 403 Dover St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Love — Last: Cooper

4. DATE OF DEATH: Month: 3 — Day: 17 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/17/1959

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never Work

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: B. Randolph Cooper

14. MOTHER'S MAIDEN NAME: Annabelle Love

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mr. Randolph Cooper, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Fatal Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO (b): Prematurity, with Multiple Prematurity (wt 4 30 gms) — "

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 17, 19 59 to Mar 17, 19 59, that I last saw the deceased alive on Mar 17, 19 59, and that death occurred at 10:40P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Saunderson Jr. M.D. — ADDRESS (Street, city or town, state): 702 Camden Avenue — DATE SIGNED

PHYSICIAN'S NAME (Type): Robert W. Saunderson, Jr., M.D. — Salisbury — Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/18/59

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

22d. LOCATION (City, town, or county) (State): Salisbury, MAryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 20 '59

24b. REGISTRAR'S SIGNATURE: Arthur S Krauss

Norman T. Baker

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03680

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 1 Mo. 4 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital

3692

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS Ocean City Rd.,
e. IS RESIDENCE ON FARM YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First Handy Middle Eugene Last Cox
4. DATE OF DEATH Month 3 Day 13 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Sept 2, 1890
9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wholesale & Retail Produce Broker
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? US.A.

13. FATHER'S NAME Franklin Cox
14. MOTHER'S MAIDEN NAME Pricilla Twigg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. Unknow
17. INFORMANT Address Mrs. Delcie Cox Salisbury, Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 9 days
DUE TO (b) Arteriosclerosis & Coronary Thrombosis — 32 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — Advanced arteriosclerosis & Hypertension
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [X] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) During truck - struck from behind by car
20c. TIME OF INJURY Hour o m p m. Month, Day, Year 2-9 1957
20d. INJURY OCCURRED While at work [ ] Not while at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) Rt 50
20f. (City or town) Rural (County) Wicomico (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Earl L Royer M.D
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED 3-16-59
EXAMINER'S NAME (Type) Earl L. Royer

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/17/59
22c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery
22d. LOCATION (City, town, or county) Siloam, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Norman F. Baker
ADDRESS Hill & Johnson Co. Salisbury, Maryland
24a. REC'D BY REGISTRAR DATE MAR 19 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2 57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3693 **CERTIFICATE OF DEATH** 03687

Reg. Dist. No.

PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen Gen Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 112 W. Vine St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle BRYAN Last CROCKETT

4. DATE OF DEATH: Month MARCH Day 25th Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 14, 1907
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months 0 Days 11
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant(Owner) Grocery Store
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Somerset Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Samuel Thomas Crockett
14. MOTHER'S MAIDEN NAME: Ida F. Dize

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
INFORMANT: Mrs. Madeline P. Crockett (Wife) Address: 112 West Vine St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumococcal Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Otitis Media Acute Serous — 4 days
DUE TO (c): Bronchopneumonia — 1 wk.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb- 1958, to March 25, 1959, that I last saw the deceased alive on 3/25 1959, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Rufus S. Gardner, Jr. M.D
ADDRESS (Street, city or town, state):
DATE SIGNED: March 28, 1959

PHYSICIAN'S NAME (Type): Dr. Rufus S. Gardner Jr. Pine Bluff Road-Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 29, 1959
22c. NAME OF CEMETERY OR CREMATORY: Spring Hill Memory Gardens
22d. LOCATION (City town or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: MAR 31 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03688

3694 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY
c. LENGTH OF STAY IN 1b 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA General HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Salisbury~~ Mardela Springs
f. STREET ADDRESS RFD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF [redacted] (Type or print) First Henry Middle Clarence Last DASHIELD

4. DATE OF DEATH Month MARCH Day 28, Year 1959.

5. SEX MALE
6. COLOR OR RACE NEGRO
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH August 15, 1887
9. AGE (In years last birthday) 71 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Mardela Springs, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Dashield
14. MOTHER'S MAIDEN NAME Elizabeth Dashield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-28-4715
[redacted] Address Mrs. Pauline Dashield, Mardela Springs, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia [illegible]
DUE TO (b) Phlebitis Right Leg
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH (a) 3 weeks (b) [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19___, that I last saw the deceased alive on _____, 19_____, and that death occurred at 9 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE William D. Elliott M.D. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED Dec 31

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF April 1, 1959
22c. NAME OF CEMETERY OR CREMATORY John Wesley Cemetery
22d. LOCATION (City, town, or county) (State) Mardela Springs, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.J. Frampton and Son, Federalsburg, Maryland
24a. REC'D BY REGISTRAR DATE MAR 31 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3695

CERTIFICATE OF DEATH

03689
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: ACCOMACK
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HALLWOOD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: HENRY Middle: T Last: Davis

4. DATE OF DEATH: Month: March Day: 9 Year: 1959

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: FEB 26, 1906
9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY T. DAVIS
14. MOTHER'S MAIDEN NAME: ELIZABETH J. GLADDING

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: MRS. INEZ L. DAVIS Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): WIDESPREAD METASTATIC CARCINOMA
163X
DUE TO (b): CARCINOMA Lung.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19___, that I last saw the deceased alive on _____, 19__, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): [illegible] DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/12/1959
22c NAME OF CEMETERY OR CREMATORY: WESSELLS CEMETERY
22d LOCATION (City, town, or county) (State): ACCOMACK VA

23 FUNERAL DIRECTOR'S SIGNATURE: Henry M. Johnson ADDRESS: Parksley Va
24a REC'D BY REGISTRAR DATE: MAR 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kuna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03690

3746

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Eden
c. LENGTH OF STAY IN 1b: all his life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route #2

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Eden
d. STREET ADDRESS: Route #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Isaac — Middle: Henry — Last: Davis

4. DATE OF DEATH: Month: 3 — Day: 3 — Year: 19 59

5 SEX: M

6 COLOR OR RACE: AA

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 11/17/1889

9 AGE (In years last birthday): 69 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Ezra Davis

14. MOTHER'S MAIDEN NAME: Leuvenia King

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16 SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Anna B. Davis, Eden, Md., Rt#2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO (b): Hypertension — Indefinite

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 24 Feb 19 59 to 3 Mar 19 59 that I last saw the deceased alive on 3 Mar 19 59, and that death occurred at ____ M, from the causes and on the date stated above

ACTUAL SIGNATURE: E Purnell, MD — ADDRESS (Street, city or town, state): 652 W Main St, Salisbury, Maryland — DATE SIGNED: 3 Mar 59

PHYSICIAN'S NAME (Type): Dr. E. A. Purnell

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/8/1959

22c NAME OF CEMETERY OR CREMATORY: Friendship Cemetery

22d. LOCATION (City, town, or county) (State): Allen, Md

23 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J.F. Stewart Funeral Home, Salisbury, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages (Pages 2 and 3) which should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with n 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3696

CERTIFICATE OF DEATH

03691

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen Gen Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 215 Washington St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle HENRY — Last DAVIS

4. DATE OF DEATH: Month MARCH — Day 3rd — Year 1959

5. SEX: Male / Female (Female struck) — 6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 28, 1885

9. AGE (In years last birthday): 73 yrs — IF UNDER 1 YEAR: Months 4 — Days 5 — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman (Employee of Clothing Co)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Elijah H. Davis

14. MOTHER'S MAIDEN NAME: Mary Jane Kelley

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Carolyn D. Davis (Wife) Address: 215 Washington St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 7 day.
DUE TO (b): cor pulmonale — 1 yr.
DUE TO (c): emphysema — 5 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

527.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1956, to Mar 5, 1959 that I last saw the deceased alive on Mar 5, 1959 and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl Beardsley, M.D.
ADDRESS (Street, city or town, state): Maryland Ave. Salisbury, Maryland
DATE SIGNED: March 4 /1959
PHYSICIAN'S NAME (Type): Dr. Earl Beardsley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 7, 1959
22c. NAME OF CEMETERY OR CREMATORY: Tyaskin Meth Cemetery
22d. LOCATION (City, town, or county) (State): Tyaskin, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: MAR 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 [illegible] 3-31-59 et

CERTIFICATE OF DEATH

3697

03692

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with n[illegible] hours after death.

VS A15 (4)
15M 10/57

1 PLACE OF DEATH
a COUNTY: Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 23 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland
b COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~XXXXXX~~ Powellville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William Middle: Elmer Last: Davis
4. DATE OF DEATH: Month: March Day: 13 Year: 1959
5 SEX: Male
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/11/1888 1888
9 AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Maryland (Parsonsburg)
12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lynn Davis
14. MOTHER'S MAIDEN NAME: Ella Kelly

15 WAS DECEASED EVER IN U S. ARMED FORCES? (Yes, no or unknown): Unk. (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.:
17 INFORMANT: Hospital Records Address: Mrs. Arthur Davis (Daughter) Willards, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Recurrent cerebral vascular accidents with left hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 2 Years

DUE TO (b): Arteriosclerosis, general — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 18, 1959, to March 13, 1959, that I last saw the deceased alive on March 13, 1959, and that death occurred at 1:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Kosmahly M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 3/13/59

PHYSICIAN'S NAME (Type): G. Kosmahly, M. D.
Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Mar. 15, 1959
22c NAME OF CEMETERY OR CREMATORY: Perdue Cemetery
22d LOCATION (City, town, or county) (State): Near Powellville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY
ADDRESS: SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: MAR 17 '59
24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3693

CERTIFICATE OF DEATH

03693
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill Rural # 2
d. STREET ADDRESS: 23X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: Dennis

4. DATE OF DEATH: Month: March — Day: 1 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 1 — 1959

9. AGE (In years last birthday): yrs

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS: Hours: 2 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Salisbury, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Sidney Dennis

14. MOTHER'S MAIDEN NAME: Dorothy Lee Purnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

INFORMANT: Mrs Helen Taylor — Address: Snow Hill, Md Rural #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

761.5

DUE TO (b): Prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Premature Separation of the Placenta

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/1 19 59 to 3/1 19 59 that I last saw the deceased alive on 3/1 19 59, and that death occurred at 7-15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John M. Bender M.D. — ADDRESS (Street, city or town, state): 104 Bay St. Snow Hill, Md. — DATE SIGNED: 3/2/59

PHYSICIAN'S NAME (Type): John M. Bender M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: March 3/59 — 22c. NAME OF CEMETERY OR CREMATORY: M.T. Wisley Cemetery — 22d. LOCATION (City, town, or county) (State): Snow Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE: Elmer E. James — ADDRESS: Snow Hill Md

24a. REC'D BY REGISTRAR DATE: MAR 3 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Kimmey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Item 9, Film G241, 4/[illegible] fr.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3699

03694

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 25 yrs.
d. NAME OF HOSPITAL OR INSTITUTION: EAST COLLEGE AVE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
d. STREET ADDRESS: EAST COLLEGE AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RATIE Middle R. Last DISHAROON

4. DATE OF DEATH: Month 3 Day 10 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 3-28-1883

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NO

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: William J. Sterling

14. MOTHER'S MAIDEN NAME: Rebecca Bennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Charles Howard — Salisbury Rt 4
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction (Acute) — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Arteriosclerotic Cardio Vascular disease — 30 yrs.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: O. J. Buxton M.D.
ADDRESS (Street, city or town, state): 211 Maryland Ave
DATE SIGNED
PHYSICIAN'S NAME (Type): O. J. Buxton, M.D. — Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-13-59
22c. NAME OF CEMETERY OR CREMATORY: Sunny Ridge
22d. LOCATION (City, town, or county) (State): Crisfield Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. S. Mamil Co
ADDRESS: Delmar Road

24a. REC'D BY REGISTRAR DATE: MAR 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3700

0369

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1½ years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 1618 Dalmor Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harold — Middle: A. — Last: Dorsey

4. DATE OF DEATH: Month: March — Day: 25th — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 24th, 1904

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isiah Dorsey

14. MOTHER'S MAIDEN NAME: Sarah Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 217-05-5551H

17. INFORMANT — Address: Deer's Head Hospital Records, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Meningioma — INTERVAL BETWEEN ONSET AND DEATH: 2 ½ yrs.

2 3X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 25, 1957, to March 25, 1959, that I last saw the deceased alive on March 25, 1959, and that death occurred at 6:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: V. Querran M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 3/25/59

PHYSICIAN'S NAME (Type): V. Querran, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/30/59

22c. NAME OF CEMETERY OR CREMATORY: New Cathedral

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Alington S. Phillips 1808-10 N. Monroe St.

24a. REC'D BY REGISTRAR: MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03696

3747 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron
c. LENGTH OF STAY IN 1b: 2 Mons.
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hebron
d STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle SPEARY Last EMRICH
4. DATE OF DEATH: Month 3 Day 11 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 4, 1881
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: George Speary
14. MOTHER'S MAIDEN NAME: Eicholtz
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): —
16 SOCIAL SECURITY NO: None
17 INFORMANT: Wm. S. Emrich, Annapolis, Md. (Address)

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia or Diuretic Cardiac Failure Due to
442X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypostatic Pneumia.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a. m. p m Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3/ /59, to 3/11/59, that I last saw the deceased alive on 3/11/59, and that death occurred at 1:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard H. Saunders M.D
ADDRESS (Street, city or town, state): Nanticoke, Md.
DATE SIGNED: 3/12/59
PHYSICIAN'S NAME (Type): Dr. Richard H. Saunders, Nanticoke, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/13/59
22c. NAME OF CEMETERY OR CREMATORY: Hebron Cemetery
22d. LOCATION (City, town, or county) (State): Hebron, Md.

23 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Hill & Johnson Co. Salisbury, MAryland
24a. REC'D BY REGISTRAR DATE: MAR 17 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

Norman T. Baker

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3701 — Reg. Dist. No. 03697

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 110 Glenn Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 110 Glenn Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NETTIE — Middle SARAH — Last FIELDS

4. DATE OF DEATH: Month MARCH — Day 30th — Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: January 24, 1886

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months 2 Days 8 — IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Employee(Shirt Factory)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Daniel A. Hitchens

14. MOTHER'S MAIDEN NAME: Mahala C. Maddox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO:

INFORMANT: Mr Vernon E. Fields (Son) Address 110 Glenn Rd. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Stroke — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (b): Hypertensive C.V. Disease — DUE TO (c):

4430

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY: Hour o m. p. m. Month Day Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/20, 1959, to 3/30, 1959, that I last saw the deceased alive on 3/30, 1959, and that death occurred at 3:50A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm B. Smith M.D. — ADDRESS (Street, city or town, state): Medical Center Salisbury Md. — DATE SIGNED: April 1-'59

PHYSICIAN'S NAME (Type): Dr. William B. Smith Medical Center Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Apr. 2, 1959

22c. NAME OF CEMETERY OR CREMATORY: Shad Point Cemetery

22d. LOCATION (City, town, or county) (State): R.D.# Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: APR 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03698

Item 3702 in G241, 4/15/59 fcy

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Res dence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 30 Keene Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ruth; Middle:; Last: Gray

4. DATE OF DEATH: Month: 3 Day: 27 Year: 19 59

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/20/1931

9. AGE (In years last birthday): 28 yrs

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Buckingham, Va.

12. CITIZEN OF WHAT COUNTRY? U.S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Rosa Smith Buckingham, Va.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: ?

17. INFORMANT: Lattie Holland Address: Buckingham, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
DUE TO
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Bullet wound of stomach, liver, left lung and left intercostal artery — 3 hours
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Shot through upper abdomen during a quarrel.

20c. TIME OF INJURY Month, Day, Year: Hour 12:20 P.M. 3-27-59

20d. INJURY OCCURRED While at work ☐ Not while at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Lunch room.

20f. (City or town) (County) (State): Salisbury Wicomico Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☑, Inspection ☑, Inquiry ☑ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☑, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

DATE SIGNED: 3-28-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-30-59
22c. NAME OF CEMETERY OR CREMATORY: Oak Grove Ch.
22d. LOCATION (City, town, or county) (State): Buckingham, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton Stewart
ADDRESS: Salisbury Md.

24a. REC'D BY REGISTRAR DATE: APR 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-7. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03699

3703 . . CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d STREET ADDRESS 209 Record St
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First ROBERT Middle THOMAS Last GREEN

4. DATE OF DEATH Month MARCH Day 1 Year 1959

5 SEX Male
6. COLOR OR RACE White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH Feb. 12, 1881
9 AGE (In years last birthday) 78 yrs
IF UNDER 1 YEAR Months 0 Days 19
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Paper Box Co.)
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) Somerset Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Robert T. Green
14. MOTHER'S MAIDEN NAME Mary Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Mrs. Lucindia Green (Wife) Address 209 Record St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia — INTERVAL BETWEEN ONSET AND DEATH 96 Hrs.

DUE TO (b) Hyperpyrexia + Acute Cerebral Vascular Disease — 72 Hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) accident — 5 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-22, 1959 to 3-1, 1959 that I last saw the deceased alive on 3/1, 1959, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wm B Smith M.D. ADDRESS (Street, city or town, state) Med Center Salisbury Md DATE SIGNED 3/1/59

PHYSICIAN'S NAME (Type) Dr. William B. Smith Medical Center Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF Mar. 4, 1959
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery
22d. LOCATION (City, town, or county) (State) Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY SALISBURY MARYLAND
24a REC'D BY REGISTRAR DATE MAR 3 '59
24b REGISTRAR'S SIGNATURE C. Elmer L. Travers

VS A1S (4) TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3704 CERTIFICATE OF DEATH

03760

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: Purnell
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Aline ~~Allie~~ — Middle: Carter — Last: Hales
4. DATE OF DEATH: Month: March — Day: 2 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: January 14, 1892
9. AGE (In years last birthday): 67 11/12
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stemstress
10b. KIND OF BUSINESS OR INDUSTRY: Shirt Factory
11. BIRTHPLACE (State or foreign country): Snow Hill, Md.
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Levin Carter
14. MOTHER'S MAIDEN NAME: Hennie Dickerson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ~~Unk~~ No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-10-4262
17. INFORMANT — Address: Hospital Records, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Old cerebral thrombosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year, 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 23 19 59, to March 2, 19 59, that I last saw the deceased alive on March 2, 19 59, and that death occurred at 11:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldve, M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital, Salisbury, Maryland — DATE SIGNED: 3/3/59

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 5 '59
22c. NAME OF CEMETERY OR CREMATORY: Whatcoat Cemetery
22d. LOCATION (City, town, or county) (State): Snow Hill, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ellis E. Dennis — ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR: DATE: MAR 5 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kuna

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03701

3705

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centreville
d. STREET ADDRESS: 415 S. Liberty Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Henrietta — Middle — Last Handy

4. DATE OF DEATH: Month March — Day 16 — Year 1959

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/24/1879

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Caleb Allen

14. MOTHER'S MAIDEN NAME: Amanda Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4-5 days

141.9

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: Ca. of tongue with metastasis to pharynx and neck — ?

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar. 12, 1959, to March 16, 1959, that I last saw the deceased alive on March 16, 1959, and that death occurred at 12:50 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: V. Juerman M.D — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 3/16/59

PHYSICIAN'S NAME (Type): V. Juerman, M. D. — Salisbury, Maryland

22a. BURIAL CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/19/59

22c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cem.

22d. LOCATION (City, town, or county) (State): Centreville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James B. Corbell, Easton

24a. REC'D BY REGISTRAR DATE: MAR 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3706 — Reg. Dist. No. 03702

1 PLACE OF DEATH
a COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 day
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Maryland — b COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d STREET ADDRESS: 217 N. Park Dr.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First GLEN — Middle TURPIN — Last HASTINGS
4. DATE OF DEATH: Month March — Day 20 — Year 1959

5 SEX: Male
6 COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Dec. 16, 1893
9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Contractor
10b KIND OF BUSINESS OR INDUSTRY: Constuction
11 BIRTHPLACE (State or foreign country): Delaware
12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Gordon Hastings
14 MOTHER'S MAIDEN NAME: Clara Turpin

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. — (If yes, give war or dates of service): ***
16 SOCIAL SECURITY NO.: 215-26-5387
17. INFORMANT: Mrs. Kathaleen P. Hastings — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO (b): lymphosarcoma, mediastinum — months
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 200.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. / p. m. 19
20d INJURY OCCURRED While at work [ ] Not while at work [ ]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-19, 1959, to 3-20, 1959, that I last saw the deceased alive on 3-20, 1959, and that death occurred at 3:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl L Royer M.D.
ADDRESS (Street, city or town, state) DATE SIGNED: 3-20-59
PHYSICIAN'S NAME (Type): Earl L. Royer, M.D. 407 Camden Ave. Salisbury, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b DATE THEREOF: 3/ 22/1959
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co., Salisbury, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

George C Hill

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13,14 rlimG240 4-3-59 et

3707

CERTIFICATE OF DEATH

03703

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 8 yrs. 5 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland
b COUNTY: Queen Anne's
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centreville
d STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Samuel — Middle — — Last Hawkins

4 DATE OF DEATH: Month March — Day 20, — Year 19 59

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 1/22/1877
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unk.
16 SOCIAL SECURITY NO:
17. INFORMANT Address: Deer's Head State Hosp. Records, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO
(b): arteriosclerotic heart disease — years
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 4 0.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ~~cerebral~~ cerebro-spinal lues; bilateral amaurosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour — o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 18, 19 50 to March 20, 19 59, that I last saw the deceased alive on March 20, 19 59, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Kosmahly M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 3/20/59

PHYSICIAN'S NAME (Type): G. Kosmahly, M. D.
Salisbury, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 3-25-59
22c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School
22d LOCATION (City, town, or county) (State): Baltimore, Md.

23 FUNERAL DIRECTOR'S SIGNATURE
ADDRESS
24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b REGISTRAR'S SIGNATURE: Clinton L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03704

3708

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springhill Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X QUANTICO
d. STREET ADDRESS: R.D.# Green Hill
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First MITCHELL — Middle EMORY — Last HOPKINS

4. DATE OF DEATH: Month MARCH — Day 25th — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Nov.17, 1887
9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months 4 — Days 8 — Hours — Min.
IF UNDER 24 HRS:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman-Employee Webb Canning Factory
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): R.D.# Salisbury, Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John M. Hopkins
14. MOTHER'S MAIDEN NAME: Margaret Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Mrs. Helen Hopkins (Wife) Address: R.D.# Green Hill Quantico, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 weeks
DUE TO (b): Generalized Arteriosclerosis — 5 Years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 3° Burns. Rt. Groin + Leg.
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/15, 1959 to 25 March, 1959 that I last saw the deceased alive on 25 March, 1959, and that death occurred at 6:25 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard H. Saunders M.D. — ADDRESS (Street, city or town, state): Nanticoke Md — DATE SIGNED: March 27 /59

PHYSICIAN'S NAME (Type): Dr. Richard H. Saunders — Nanticoke, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar.28,1959
22c. NAME OF CEMETERY OR CREMATORY: Mardela Cemetery (Old Part)
22d. LOCATION (City, town, or county) (State): Mardela, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REG STRAR DATE: MAR 31 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3709

CERTIFICATE OF DEATH

Reg. Dist. No. 03705

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 yr 4½ mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air 12X-2
d. STREET ADDRESS: County Alms House
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

91

3 NAME OF DECEASED (Type or print): First: Noah; Middle: Pearson; Last: Jackson

4. DATE OF DEATH: Month: March; Day: 19th; Year: 19 59

5 SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 14, 1897

9. AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Jackson

14 MOTHER'S MAIDEN NAME: Alice McMillan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unk. except for National Guard

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Deer's Head State Hospital Records, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute heart failure — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic cardiovascular disease — Years

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Residual left monoplegia and dysarthria due to old cerebral thrombosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 5, 1956, to March 19, 1959, that I last saw the deceased alive on March 19, 1959, and that death occurred at 9:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Kosmahly M D

ADDRESS (Street, city or town, state): Deer's Head State Hospital

DATE SIGNED: 3/20/59

PHYSICIAN'S NAME (Type): G. Kosmahly, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: Mar. 24, 1959

22c. NAME OF CEMETERY OR CREMATORY: Greenmount

22d. LOCATION (City, town, or county) (State): Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William Cook, Inc. 1217 St. Paul Street

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03706

3710

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 13 Days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Virginia
b. COUNTY Accomac
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chincoteague
d STREET ADDRESS Clark Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Margaret Middle Ann Last Tester
4 DATE OF DEATH Month March Day 31 Year 1959

5 SEX Female
6 COLOR OR RACE White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH March 10, 1868
9. AGE (in years last birthday) 91 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Virginia
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Carpenter
14. MOTHER'S MAIDEN NAME Elizabeth Cherrix

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
INFORMANT Address Hallie Pettit- New Church, Virginia

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 3/18, 1959, to 3/31, 1959, that I last saw the deceased alive on 3/31, 1959, and that death occurred at 5:34 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE William R. Ellis Jr. M.D. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 4/3/59

PHYSICIAN'S NAME (Type) W. R. Ellis Jr.

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF April 3, 1959
22c NAME OF CEMETERY OR CREMATORY Greenbackville Cemetery
22d LOCATION (City, town, or county) Greenbackville (State) Virginia

23. FUNERAL DIRECTOR'S SIGNATURE William B. Lalyer
ADDRESS Chincoteague, Va.
24a REC'D BY REG STRAR DATE APR 6 '59
24b REGISTRAR'S SIGNATURE Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1S (4)
1SM 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3711 Item 1 Film 0240 5-20-59 et

037707

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): At home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury
d. STREET ADDRESS: Raynor Farm
e. IS RESIDENCE ON A FARM? YES X NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: J — Last: Jones

4. DATE OF DEATH: Month: 3 — Day: 12 — Year: 19 59

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1900

9. AGE (In years last birthday): 59 yrs

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Westover, Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Edward Hall

14. MOTHER'S MAIDEN NAME: Sarah Jones Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 219-01-4744

17. INFORMANT: Sheriff of Wicomico County
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 Hours
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, X Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3-17-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-19-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

22d. LOCATION (City, town, or county) (State): Smithfield Md

23. FUNERAL DIRECTOR'S SIGNATURE: Benton & Leach
ADDRESS

24c. REC'D BY REGISTRAR DATE: MAR 2 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

I

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3712

CERTIFICATE OF DEATH

Reg. Dist. No. 03708

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: None.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springhill Sanitarium

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d STREET ADDRESS: 306 S. Clermont Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edna — Middle: Earle — Last: Loreman

4. DATE OF DEATH: Month: March — Day: 19 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 12, 1880
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John P. Tawes
14 MOTHER'S MAIDEN NAME: Mary Susan White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): None (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: H.L.Loreman Jr. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

4X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Infection - Bed Sores
DUE TO (c): Senile Debility

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 19 59 to 3/14 19 59 that I last saw the deceased alive on 3/14 19 59, and that death occurred at 8:30 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: W. B. Smith M.D
ADDRESS (Street, city or town, state): Med. Center Sby. Md.
DATE SIGNED: 3/17/59

PHYSICIAN'S NAME (Type): Dr. William Smith. Medical Center, Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/21/1959
22c. NAME OF CEMETERY OR CREMATORY: Sunny Ridge Cemetery
22d LOCATION (City, town, or county) (State): Crisfield, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland
24a REC'D BY REGISTRAR DATE: MAR 20 '59
24b REGISTRAR'S SIGNATURE: Arthur S Haas

Norman F. Baker

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03709

Reg. Dist. No. 3748

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Route #2 Eden
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Route #2 Eden
d. STREET ADDRESS: R 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Lida — Middle Mae — Last Malone
4. DATE OF DEATH: Month Mar. — Day 20, — Year 19 59

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Nov. 10, 1896
9. AGE (In years last birthday): 62 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George William Moore
14. MOTHER'S MAIDEN NAME: Julia Ann Newton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT — Address: Frank Malone, Route#2, Eden, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 5 month,
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 19 58, to March 20 or 19 59, that I last saw the deceased alive on March 21, 19 59, and that death occurred at 12 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William D Gray M.D
ADDRESS (Street, city or town, state): 334 Camden Ave Salisbury Md
DATE SIGNED: 3/28/59
PHYSICIAN'S NAME (Type): William D Gray

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/25/59
22c. NAME OF CEMETERY OR CREMATORY: Allen Cemetery
22d. LOCATION (City, town, or county) (State): Allen Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: James Dennis
ADDRESS: Princess Anne, Md.
24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 See: Birth Cert. et

3713

CERTIFICATE OF DEATH

Reg. Dist. No. 03710

1 PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND: Md

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md
b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: P.G.H.

d. STREET ADDRESS: Box 37

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Tommie; Middle:; Last: Mills

4. DATE OF DEATH: Month: March; Day: 4th; Year: 19 59

5. SEX: Mal.

6. COLOR OR RACE: Col'd.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 25, 1958

9. AGE (In years last birthday) yrs: IF UNDER 1 YEAR Months: 3; Days:; IF UNDER 24 HRS Hours:; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salisbury Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joshua Mitchell

14. MOTHER'S MAIDEN NAME: Lucille Mills

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Lucille Mills
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO:
49°
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c): (Primary Prematurity)

INTERVAL BETWEEN ONSET AND DEATH: 10 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
1) Congenital Heart Disease 2) Intracranial Hemorrhage (Prematurity)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/11 19 59 to 3/4 19 59 that I last saw the deceased alive on 3/4 19 59, and that death occurred at 6 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred C. Kelly M.D.
ADDRESS (Street, city or town, state): Miland Center, Salisbury
DATE SIGNED: 3/7/59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-5-59
22c. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
22d. LOCATION (City, town, or county): Fruitland (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Booker M. West
ADDRESS:

24a. REC'D BY REGISTRAR DATE MAR 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

2082/151/XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3749

CERTIFICATE OF DEATH

Reg. Dist. No. 0371i

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bivalve
c. LENGTH OF STAY IN 1b: One day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waterview, Maryland
f. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: Westley; Last: Moore
4. DATE OF DEATH: Month: March; Day: 23; Year: 1959
5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/15/1881
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oysterman
10b. KIND OF BUSINESS OR INDUSTRY: Waterman
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Nicholas Moore
14. MOTHER'S MAIDEN NAME: Nellie Wilson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-36-5302
17. INFORMANT: Eva Moore — Address: Waterview, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Unkn.
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — 10 years
DUE TO (c):
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 15 Feb 1957, 23 March 1959 that I last saw the deceased alive on 23 March 1959, and that death occurred at 9:15 A.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Richard H. Saunders M.D. ADDRESS (Street, city or town, state): Nanticoke, Maryland DATE SIGNED: 3/24/59
PHYSICIAN'S NAME (Type): Richard H. Saunders M.D. Nanticoke Md 3/24/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/25/59
22c. NAME OF CEMETERY OR CREMATORY: Turner's Cemetery
22d. LOCATION (City, town or county) (State): Nanticoke, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: C. T. Parsley Funeral Home
24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03712

3714 Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15ME
5M 2/57

1. PLACE OF DEATH
a COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen Gen Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Maryland — b COUNTY: Wicomico
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d STREET ADDRESS: 325 Penn St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HERMAN — Middle MERRILL — Last MUMFORD

4. DATE OF DEATH: Month MARCH — Day 8 th — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept.5,1915

9. AGE (In years last birthday): 43 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer-Roofer(Sal.Roofing Co.)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Virgil M. Mumford

14. MOTHER'S MAIDEN NAME: Cornelia Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W W II

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Mrs.Alfrenia Mumford(Wife) 325 Penn St Salisbury,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture of cervical Spine
830x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Car jacked up for repairs and fell on deceased.

20c. TIME OF INJURY: Hour 10:50 o. m. P A.M. — Month, Day, Year 3-8-59

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Yard at home

20f. (City or town) Salisbury (County) Wicomico (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D

EXAMINER'S NAME (Type): Dr. Earl L. Royer

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: March 9 /1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar.11,1959

22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery

22d. LOCATION (City, town, or county) (State): Walston Mem.R.D.#4 (Salisbury, Md.)

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY
ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: MAR 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3715

CERTIFICATE OF DEATH

Reg. Dist. No. 03713

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 10 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 516 E. Locust St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLARD — Middle ASBURY — Last MUMFORD

4. DATE OF DEATH: Month MARCH — Day 26 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 16, 1886

9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee-Citizen Gas. Co. (Retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Snow Hill, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George Mumford

14. MOTHER'S MAIDEN NAME: Fannie Bethards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
If yes, give war or dates of service:

16. SOCIAL SECURITY NO:

INFORMANT: Mrs. May (Mabel) B. Mumford (Wife) Address: 516 E. Locust St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 days

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Hypertensive Cardiovascular disease — ?

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/16/59, 19 59, to 3/26/59, 19 59, that I last saw the deceased alive on 3/26/59, 19 59, and that death occurred at 7:05 p. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Alberta Mattax M.D. — ADDRESS (Street, city or town, state): 711 Camden Ave, City — DATE SIGNED: 3/26/59

PHYSICIAN'S NAME (Type): Dr. Alberta Mattax — 711 Camden Ave. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 29, 1959

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: MAR 31 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3716 CERTIFICATE OF DEATH

Reg. Dist. No. 03714

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Delaware
b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar 4 ½
d. STREET ADDRESS: State Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle THOMAS — Last O'NEIL

4. DATE OF DEATH: Month March — Day 26 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 15, 1884

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REtired

10b. KIND OF BUSINESS OR INDUSTRY: RR Conductor

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry O'Neil

14. MOTHER'S MAIDEN NAME: Laura Whaley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: Mrs. Doris J. Savage, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Degenerative Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: unknown
42.2.2
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/2, 1959 to 3/26, 1959 that I last saw the deceased alive on 3/26, 1959, and that death occurred at ——— M, from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D.: Wilbur R. Ellis Jr. M.D. — ADDRESS (Street, city or town, state): Dukes Bldg., Md. — DATE SIGNED: 3/28/59

PHYSICIAN'S NAME (Typed): Wilber R. Ellis, Jr. — Medical Center, Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/28/1959
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & JohnsonnCo., Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

Burge C. Hill II

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be released by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3717

CERTIFICATE OF DEATH

Reg. Dist. No. 03715

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Merritt Mill Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First 010N — Middle JACOB — Last Parker

4. DATE OF DEATH: Month March — Day 29 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 2, 1898

9. AGE (In years last birthday): 60 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Owner

10b. KIND OF BUSINESS OR INDUSTRY: Truck

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stanton Parker

14. MOTHER'S MAIDEN NAME: Priscella Hamblin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 217-36-0838

INFORMANT: Mrs. O.J. Parker, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Heart Disease
DUE TO (b): Coronary Atherosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4.2.3.1

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour — a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1956 to March 29, 1959 that I last saw the deceased alive on March 29 1959 and that death occurred at 6 45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: David J Gilmore M.D.
ADDRESS (Street, city or town, state): Salisbury Md
DATE SIGNED: March 29 1959

PHYSICIAN'S NAME (Type): Dr. David J. Gilmore Medical Center, Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/31/59
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: APR 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

Norman T. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3718 CERTIFICATE OF DEATH

Reg. Dist. No. 03716

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

1 PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury	c. LENGTH OF STAY IN 1b
	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Sanitarium Inc.	d. STREET ADDRESS: R.D.# 4 — e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ROSA	MAY	PARKER	MARCH	21st	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		May 24, 1867	91 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House W rk at Home	None	Wico.Co.Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
J.Mitchell Collins	Martha Washington Mills

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
No		Mr. Albert Parker (Son) R.D.# 4 Salisbury, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio vascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO

42 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II OTHER S GNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from _____, 19 58, to 3-21, 19 59 that I last saw the deceased alive on 3-21, 19 59, and that death occurred at 9:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Philip A Insley M D. — ADDRESS (Street, city or town, state) — DATE SIGNED March 23/1959

PHYSICIAN'S NAME (Type) Dr. Philip A. Insley — Main St. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Mar. 24, 1959	Wicomico Memorial Park	Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY SALISBURY MARYLAND	MAR 24 '59	Clifton S Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,8,11 Film 6240 4-2-59 et

3719

CERTIFICATE OF DEATH

03717

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne 19X-2
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First — Middle — Last: Parks

4. DATE OF DEATH: Month: March — Day: 20 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 20, 1959
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME: SHERDON PARKS
14 MOTHER'S MAIDEN NAME: WILMETTA JONES

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO
INFORMANT Address: SHERDON PARKS, PRINCESS ANNE, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Immaturity. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Premature rupture of membranes & delivery.
'161.5
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3/20 19 59, to ____ 19__, that I last saw the deceased alive on 3/20 19 59, and that death occurred at 1:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen W. Lutz M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/22/59
22c NAME OF CEMETERY OR CREMATORY: JOHN WESLEY
22d LOCATION (City, town, or county) (State): PRINCESS ANNE, MARYLAND

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: WILLIAM H. JAMES JR. PRINCESS ANNE, MD
24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b REGISTRAR'S SIGNATURE: Clifton L. Horner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3720

Reg. Dist. No. 0371

1 PLACE OF DEATH
a COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 17 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springhill Sanitarium, Inc.

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a STATE: Maryland — b COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d STREET ADDRESS: Rt. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Horace — Middle G. — Last Payne
4. DATE OF DEATH: Month Mar. — Day 4, — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 15, 1881
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Business
10b KIND OF BUSINESS OR INDUSTRY: Farming Real Estate
11 BIRTHPLACE (State or foreign country): Accomoke City
12 CITIZEN OF WHAT COUNTRY: U. S. A.

13 FATHER'S NAME: William H Payne
14 MOTHER'S MAIDEN NAME: Sarah E. Hancock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17 INFORMANT: Mrs Nellie B. Payne, Address Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO (b): Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Diabetes Mellitus Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/10, 19 59, to Mar. 4, 19 59, that I last saw the deceased alive on 3/4 1959, and that death occurred at 9:45 P M, from the causes and on the date stated above

ACTUAL SIGNATURE: David J Gilmore M.D. — ADDRESS (Street, city or town, state): Medical Center, Salisbury, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. David J. Gilmore

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 7/59
22c. NAME OF CEMETERY OR CREMATORY: Whaleyville Cemetery
22d LOCATION (City, town, or county) (State): Snow Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE: Lilly & Timmis — ADDRESS: Snow Hill, Md
24a REC'D BY REGISTRAR DATE: MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3721

Reg. Dist. No. 03713

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 807 E.William St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 807 E.William St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHARD — Middle F. — Last PERRY

4. DATE OF DEATH: Month MARCH — Day 28th — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept.18,1864

9. AGE (In years last birthday): 94 yrs
IF UNDER 1 YEAR: Months 6 Days 10
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Tin Smith

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Salisbury,Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Richard Perry

14. MOTHER'S MAIDEN NAME: Sarah Hobbs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

INFORMANT: Mr.Richard A.Perry(Son) Address: 201 New York Ave. Salisbury,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO (b): Arteriosclerotic Cardiovascular disease — 15 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 57 to Mar 25, 19 59 that I last saw the deceased alive on Mar 25, 19 59, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Alberta Mattax M.D. ADDRESS (Street, city or town, state): 711 Camden Ave DATE SIGNED: March 30 1959

PHYSICIAN'S NAME (Type): Dr.Alberta Mattax 711 Camden Ave. Salisbury,Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar.31,1959

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury,Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: MAR 31 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03720

Reg. Dist. No. 3722

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
d. STREET ADDRESS: Bay Ridge Farm
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Nancy Middle KATHRYN Last Purnell
4. DATE OF DEATH: Month 3-26- Day Year 1959
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN. 28 1942
9. AGE (In years last birthday): 17 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PUPIL
10b. KIND OF BUSINESS OR INDUSTRY: HIGH SCHOOL
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM M. PURNELL
14. MOTHER'S MAIDEN NAME: KATHRYN QUILLEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: WILLIAM M. PURNELL Address: OCEAN CITY, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured cervical spine — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Passenger in car that ran off road andturned over.
20c. TIME OF INJURY: Hour 12 P.M. Month, Day, Year 3-26-59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town): Berlin (County): Worcester (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
DATE SIGNED: 3-28-59

22a. BURIAL CREMATION REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/29/59
22c. NAME OF CEMETERY OR CREMATORY: Odd Fellows
22d. LOCATION (City, town, or county): Bishopville (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Anna D. Burbage
ADDRESS: Berlin Md
24a. REC'D BY REGISTRAR DATE: APR 1 '59
24b. REGISTRAR'S SIGNATURE: Charles S. Kroma

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2'57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3723

0372

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
d. STREET ADDRESS: Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Jacob — Middle Cannon — Last Savage

4. DATE OF DEATH: Month March — Day 3 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 2, 1878

9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Delmar

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: William T. Savage

14. MOTHER'S MAIDEN NAME: Nancy E. Gunby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Hospital Records, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinomatosis, generalized — INTERVAL BETWEEN ONSET AND DEATH: ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Carcinoma of prostate — ?

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from February 17, 1959, to March 3, 1959, that I last saw the deceased alive on March 3, 1959, and that death occurred at 6:20A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Kosmahly M D — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 3/3/59

PHYSICIAN'S NAME (Type): G. Kosmahly, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/4/59

22c. NAME OF CEMETERY OR CREMATORY: New Hope Cem.

22d. LOCATION (City, town, or county) (State): WILLARDS MARYLAND.

23. FUNERAL DIRECTOR'S SIGNATURE: Watson & Fry — ADDRESS: Frankford.

24a. REC'D BY REGISTRAR DATE: MAR 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3724

CERTIFICATE OF DEATH

Reg. Dist. No. 03722

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware — b. COUNTY: Sussex

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b: 1 Day

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seaford

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

d. STREET ADDRESS: 620 East High St.,

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: Schaefer

4. DATE OF DEATH: Month: March — Day: 14 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 13, 1959

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: Hours: 6 Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wesley Schaefer

14. MOTHER'S MAIDEN NAME: Joyce Richardson

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): - -

16 SOCIAL SECURITY NO: None

INFORMANT Address: Mr. Wesley Schaefer, Seaford, Del.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Atelelectasis — INTERVAL BETWEEN ONSET AND DEATH

762.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Prematurity (Birth wt. 1165 gms) — 6 hrs

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3/13 19 59 to 3/14 19 59 that I last saw the deceased alive on 3/14 19 59, and that death occurred at 5 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred C. Kells, M.D. — ADDRESS (Street, city or town, state): Medical Center, Salisbury, Maryland — DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. Alfred C. Kells

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 3/15/59

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

22d LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, MAryland

24a. REC'D BY REGISTRAR DATE: MAR 17 '59

24b REGISTRAR'S SIGNATURE: Arthur L. Thawa

Norman T. Baker

XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3725 **CERTIFICATE OF DEATH** 03723

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop 23 x 2
d STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First HARLEY Middle J. Last Selby

4. DATE OF DEATH: Month March Day 19 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 21, 1884
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sampson Selby
14. MOTHER'S MAIDEN NAME: Ellen Holloway

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown) — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Mrs Cida Massey Address: Bishop Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
3 x 2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
DUE TO (b):
DUE TO (c):

PART II OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G VEN IN PART 1(a)
19. WAS A AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)
20c. TIME OF NJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-23, 1959, to 3-19, 1959, that I last saw the deceased alive on _____, 19_____, and that death occurred at 6:57 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William D. Elliott M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 3-20-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMAT ON, REMOVAL (Spec fy): Burial
22b. DATE THEREOF: 3/22/59
22c. NAME OF CEMETERY OR CREMATORY: D.C.C.F.
22d. LOCATION (City, town, or county) (State): Berlin Md

23. FUNERAL DIRECTOR'S SIGNATURE: Tilden Whaley — ADDRESS: Lillyville Md.
24a. REC'D BY REGISTRAR DATE: MAR 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3726

CERTIFICATE OF DEATH

03724

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 11 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SNOW HILL
d STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Morris — Middle: — Last: SILVERMAN

4. DATE OF DEATH: Month: MARCH — Day: 7 — Year: 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: (UNK) 1888

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: UNK

14. MOTHER'S MAIDEN NAME: UNK

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): UNK
(If yes, give war or dates of service):

16 SOCIAL SECURITY NO: 214-32-7374

INFORMANT (Address): Mrs. Jack Rudolph (Daughter) 37 Cuyp Brook Parkway - Cuyp brook Hills PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Degenerative Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
422.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Tuberculosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 2-24, 1957 to 3-1, 1957 that I last saw the deceased alive on 3-7, 1957, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Wilbur R. Ellis / M.D. 3-7-57

PHYSICIAN'S NAME (Type): Dr. Wilbur R Ellis Jr. Medical Center - Salisbury Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 3-8-57

22c NAME OF CEMETERY OR CREMATORY: Har Nebo Mem.

22d LOCATION (City, town, or county) (State): Philadelphia PA.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Holloway Company - Salisbury Md.

24a. REC'D BY REGISTRAR: MAR 10 '59

24b REGISTRAR'S SIGNATURE: Arthur S Krause

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3727

CERTIFICATE OF DEATH

Reg. Dist. No. 03725

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula Gen Hosp

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 314 Ellen Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: Simmons — Last:
4. DATE OF DEATH: Month: 3 — Day: 11 — Year: 19 59

5. SEX: M
6. COLOR OR RACE: AA
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/12/1901
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Painting
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 240 12 5183
17. INFORMANT — Address: Mrs. Pauline Dickerson, Salisbury, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — hypostatic + bacterial — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Left cerebral hemorrhage — 1 month
DUE TO (c): Hypertensive cardiovascular disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443x

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypostatic
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2/7/59, 19__, to 3/11/59, 19__, that I last saw the deceased alive on 3/10/59, 19__, and that death occurred at __M, from the causes and on the date stated above

ACTUAL SIGNATURE: O. J. Burton M.D
ADDRESS (Street, city or town, state): 211 Maryland Avenue
DATE SIGNED: 3/11/59

PHYSICIAN'S NAME (Type): O. J. Burton, M.D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/14/1959
22c. NAME OF CEMETERY OR CREMATORY: Green Acre Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. F. Stewart Funeral Home, Salisbury, Md
24a. REC'D BY REGISTRAR DATE: MAR 17 59
24b. REGISTRAR'S SIGNATURE: Vivian S. Truitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03726

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)
c. LENGTH OF STAY IN 1b App: 2wks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D.# Johnson Road

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS 321 Newton St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	FULTON	KNIGHT	SINGLETON		MARCH	14th	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
Male	White		March 1st, 1922	37 yrs.	0	13		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer - Lumberman	Lumber	Hillsdale N.J.	U S A

13. FATHER'S NAME: Edward S. Singleton
14. MOTHER'S MAIDEN NAME: Martha Kirkpatrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
YES	W.W.II		Mrs. Dora R. Singleton (Wife)	321 Newton St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Attended family Car explosion

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☑	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
	3-14 1959		Home	Wango	Wicomico	Md.

21 I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Earl L Royer M.D.

EXAMINER'S NAME (Type) Dr. Earl L. Royer

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED March 25 /1959

22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	Mar. 30, 1959	Geo. Washington Mem. Park	Paramus,	New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND

24a. REC'D BY REGISTRAR DATE MAR 31 '59

24b. REGISTRAR'S SIGNATURE Arthur L. Travers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 [illegible] 3-30-59 et

3728 Item 2 [illegible] 3-31-59 et

CERTIFICATE OF DEATH

03727

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X /Salisbury/ Pittsville
d. STREET ADDRESS: /John B. Parson Home/ None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First REBECCA Middle SHOCKLEY Last SMITH

4. DATE OF DEATH: Month 3 Day 23 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 9, ~~1873~~ 1874
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Practrical
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eljah R. Shockley
14. MOTHER'S MAIDEN NAME: Amanda Riggin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: Unknow
17. INFORMANT Address: John B. Parsons Home Records Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of liver & metastasis — 2 yrs
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1959 to 3/23, 1959 that I last saw the deceased alive on 3/23, 1959, and that death occurred at 9:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Alberta Mattux M.D. — ADDRESS (Street, city or town, state): 711 Camden Ave — DATE SIGNED: 3/24/59

PHYSICIAN'S NAME (Type): Dr. ALBERTA MATTUX 711 CAMDEN AVE. ~~Dr. Carrie Mann, 226 N. Division St.~~, Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/24/1959
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Corinne L. Krause

Norman T. Baker

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3729

CERTIFICATE OF DEATH

Reg. Dist. No 13728

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b: 6 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill — Rural #1
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Martha — Middle J. — Last Smullen
4. DATE OF DEATH: Month March — Day 7 — Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 15 1888
9. AGE (In years last birthday): 70 Yrs 5 Mos 22 Days
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Salisbury, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel H. Truitt
14. MOTHER'S MAIDEN NAME: Mary Leggie Wenskey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
INFORMANT: Mr. James C. Smullen, Address Snow Hill Md. Rural #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
422.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c) Degenerative Heart Disease — Long duration

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-1, 1959 to 3-7, 1959, that I last saw the deceased alive on 3-7, 1959, and that death occurred at 12:02 M, from the causes and on the date stated above.
ACTUAL SIGNATURE William R. Ellis, Jr. M.D. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 3-8-59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF May 9/59
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) (State) Snow Hill Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Norman F. Timms — ADDRESS: Snow Hill Md.
24a. REC'D BY REGISTRAR DATE MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3730

CERTIFICATE OF DEATH

03729

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Denton
d. STREET ADDRESS: R 2, Box 190
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Alfred — Last: Stanley

4. DATE OF DEATH: Month: March — Day: 18 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 20, 1895

9. AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Day Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Type of Factory unknown

11. BIRTHPLACE (State or foreign country): Hurlock, Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Harison Stanley

14. MOTHER'S MAIDEN NAME: Lurenda Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ~~Unk~~ Yes WWI

16. SOCIAL SECURITY NO: 160-14-2008

17. INFORMANT: Hospital Records, Address: Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Recurrent cerebral hemorrhage — 5 days

DUE TO

(c): Hypertensive arteriosclerotic cardiovascular disease — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 9, 1959, to March 18, 1959, that I last saw the deceased alive on March 18, 1959, and that death occurred at 8:10A M. from the causes and on the date stated above

ACTUAL SIGNATURE: V. Juerman M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 3/18/59

PHYSICIAN'S NAME (Type): V. Juerman, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 21, 1959

22c. NAME OF CEMETERY OR CREMATORY: Federal Hill Cemetery

22d. LOCATION (City, town, or county) (State): Federalsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: J.J.Frampton and Son, Federalsburg, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 23 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 r... 2279 3-11-59 et

CERTIFICATE OF DEATH

3731

Reg. Dist. No. 03730

1. PLACE OF DEATH
a COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 29 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland — b COUNTY: Dorchester
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Secretary
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle Wesley — Last Stevens
4. DATE OF DEATH: Month March — Day 3 — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/28/1887
9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic-Ret.
10b KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jesse Stevens
14 MOTHER'S MAIDEN NAME: Sarah Carroll

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of lung (right) — INTERVAL BETWEEN ONSET AND DEATH:

163 X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 2, 1959, to March 3, 1959, that I last saw the deceased alive on March 3, 1959, and that death occurred at 8:45 P. M, from the causes and on the date stated above

ACTUAL SIGNATURE: G. Kosmahly M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 3/4/59

PHYSICIAN'S NAME (Type): G. Kosmahly, M. D.
Salisbury, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 3/6/59
22c NAME OF CEMETERY OR CREMATORY: Liberty Memorial
22d LOCATION (City, town, or county) (State): Linkwood, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Leslie S. Willoughby
ADDRESS: E. New Market, Md.

24a. REC'D BY REGISTRAR DATE MAR 6 '59
24b REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03731

3732

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1 PLACE OF DEATH
a COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 334 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland
b COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield
d STREET ADDRESS: P.O. Box 454
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Grant — Middle — Last Taylor

4. DATE OF DEATH: Month March — Day 1 — Year 19 59

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 1, 1889
9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country): Rehobeth, Md.
12 CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: George Taylor
14. MOTHER'S MAIDEN NAME: Rose Wilkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.
17 INFORMANT — Address: Hospital Records, Salisbury, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 min
420.1
DUE TO (b): Arteriosclerotic cardiovascular disease — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Osteomyelitis of sacrum
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m — Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from April 1, 19 58 to March 1, 19 59 that I last saw the deceased alive on March 1, 19 59, and that death occurred at 8:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: V. Juerman M D
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 3/2/59

PHYSICIAN'S NAME (Type): V. Juerman, M. D.
Salisbury, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify)
22b DATE THEREOF: 3-5-59
22c ~~NAME OF CEMETERY OR CREMATORY~~: U. of Md. Med. School
22d LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a REC'D BY REGISTRAR DATE MAR 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kime

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3733 Item 1 Aug. 41 4-6-59 e+

CERTIFICATE OF DEATH

Reg. Dist. No. 03732

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b: 35 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 727 Dennis St. (Boarding House)

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Md
b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS 727 Sunset Heights
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Raymond Middle — Last Taylor
4. DATE OF DEATH: Month March Day 25 Year 1959
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 10 1898
9. AGE (In years last birthday): 60/10
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Tenant
11. BIRTHPLACE (State or foreign country): Snow Hill, Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John H. Taylor
14. MOTHER'S MAIDEN NAME: Bessie J. Dale
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs Sarah Taylor — Address: Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertension Cerebral Hemorrhage Rural #2 — Interval between onset and death: 5 years
DUE TO
(b): Hypertension — Unk
DUE TO
(c): Arteriosclerosis — Unk
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 23, to March 25, 1959, that I last saw the deceased alive on March 17, 1959, and that death occurred at 9:55 M, from the causes and on the date stated above.
ACTUAL SIGNATURE OF PHYSICIAN: G Herbert Sembly, M.D. — ADDRESS (Street, city or town, state): 402 Edgemont St. Salisbury Md — DATE SIGNED: 3/26/59
PHYSICIAN'S NAME (Type): G. Herbert Sembly

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 28/59
22c. NAME OF CEMETERY OR CREMATORY: Taylor Family Cemetery
22d. LOCATION (City, town, or county) (State): Snow Hill Md
23. FUNERAL DIRECTOR'S SIGNATURE: Alley E. Timms — ADDRESS: Snow Hill Md
24c. REC'D BY REGISTRAR DATE MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Timms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with in 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3734

CERTIFICATE OF DEATH

03733

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 503 Mitchell St

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 503 Mitchell St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANCES Middle BARRANCO Last TESTA

4. DATE OF DEATH: Month MARCH Day 3rd Year 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 8, 1873
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months 11 Days 24
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Cefalu Italy
12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: Giovanni(John) Barranco
14. MOTHER'S MAIDEN NAME: Maria Grazia Maghiola

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
INFORMANT: Mr. John Testa (Son) Address: 407 Royal St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO (b): Senility
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

433.0

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/28/58, 19__, to 3/5/59, 19__, that I last saw the deceased alive on 3/2/59, 19__, and that death occurred at 1:48 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A C Mitchell M.D.
ADDRESS (Street, city or town, state): 211 Maryland
DATE SIGNED: March 5 /1959

PHYSICIAN'S NAME (Type): Dr. Andrew C. Mitchell Maryland Ave. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 5, 1959
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: MAR 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3735 **CERTIFICATE OF DEATH** 03734

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b: App: 1 wk
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 332 Camden Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle B. Last Truckenmiller

4. DATE OF DEATH: Month March Day 12 Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 29, 1879

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Highway Dept. Employee

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Allenwood, Pa.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William C. Truckenmiller

14. MOTHER'S MAIDEN NAME: Martha Bryson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Mr. George A. Wollet (Son-In-Law) Address: 332 Camden Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): ~~Myo~~ Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO (b): Myocardial Infarction — ~~9~~ 9 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerotic C-V Disease — 7

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

420.1

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec, 19 58, to March 12, 19 59, that I last saw the deceased alive on March 12, 19 59, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William D Gray M.D

ADDRESS (Street, city or town, state): 334 Camden Ave

DATE SIGNED: 3/12/59

PHYSICIAN'S NAME (Type): Dr. William D. Gray 334 Camden Ave. Salisbury, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: Mar. 16, 1959

22c. NAME OF CEMETERY OR CREMATORY: Muncy Cemetery

22d LOCATION (City, town, or county) (State): Muncy, Pa.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: MAR 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G240, 3/31/59 jcy

3736

CERTIFICATE OF DEATH

0373[illegible]

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2 USUAL RESIDENCE (Where deceased lived If institution Res dence before adm ssion) a. STATE: Maryland b. COUNTY: Wicomico
b CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b: 6 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Eden
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula Gen. Hosp	d STREET ADDRESS: Route # 2 — e IS RESIDENCE ON A FARM? YES ☐ NO ☒
3 NAME OF DECEASED (Type or print): First Seymore Middle — Last Wallace	4 DATE OF DEATH: Month 3 Day 11 Year 1959
5 SEX: Male — 6. COLOR OR RACE: Negro — 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8 DATE OF BIRTH: 6/10/1900 — 9 AGE (In years last birthday): 58 yrs — IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming — 10b KIND OF BUSINESS OR INDUSTRY: Farm — 11 BIRTHPLACE (State or foreign country): South Carolina — 12 CITIZEN OF WHAT COUNTRY: USA	
13 FATHER'S NAME: Clarence Wallace — 14 MOTHER'S MAIDEN NAME: Ellen Boulson	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No — 16 SOCIAL SECURITY NO — 17 INFORMANT Address: Mrs. Mary Wallace, Eden, Md. Route 2	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Cerebral Thrombosis	2 days
420.1 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Myocardial Infarction	4 days
DUE TO (c)	Pulmonary Edema	1 day

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO ~~DEATH BUT NOT RELATED~~ TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar. 6, 1959 to Mar. 11, 1959 that I lost saw the deceased alive on March 10, 1959, and that death occurred at 7.25 M, from the causes and on the date stated above

ACTUAL SIGNATURE: G Herbert Sembly M.D. — ADDRESS (Street, city or town, state): 400 E. Church St. Salisbury — DATE SIGNED: 3/12/59

PHYSICIAN'S NAME (Type): Herbert G. Sembly, MD — Salisbury, Md.

22a BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/15/1959	Jordan Baptist Cemetery	Barnwell, South Carolina

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. F. Stewart Funeral Home, Salisbury, Md.

24a REC'D BY REGISTRAR DATE: MAR 17 '59 — 24b REGISTRAR'S SIGNATURE: Arthur S. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3737

CERTIFICATE OF DEATH

03736

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY
c. LENGTH OF STAY IN 1b 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Bivalve
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Carl Middle L Last WALTER
4. DATE OF DEATH Month MARCH Day 6 Year 1959
5. SEX MALE
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10/25/1896
9. AGE (In years last birthday) 62 yrs
IF UNDER 1 YEAR Months 4 Days 11
IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor of Assessments of Wic. County
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Benside Walter
14. MOTHER'S MAIDEN NAME Ella Laxmore Jessie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 220-12-0503
INFORMANT Dolores Lee Walter, Wife
Address Bivalve, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
433.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis with
DUE TO (c) Uncontrolled DM

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Right Pneumonia - Lung for Circulation of Fluid
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o m p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 3, 1958 to March 6, 1959, that I last saw the deceased alive on March 6, 1959, and that death occurred at 902 A M, from the causes and on the date stated above.
ACTUAL SIGNATURE Thomas C Hill Jr M.D.
ADDRESS (Street, city or town, state) Pine Bluff Road
DATE SIGNED
PHYSICIAN'S NAME (Type) Thomas C. Hill Jr. Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/8/59
22c. NAME OF CEMETERY OR CREMATORY Bivalve Cem.
22d. LOCATION (City, town, or county) Bivalve (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. W. Truitt
ADDRESS Bivalve, Md.
24a. REC'D BY REGISTRAR DATE MAR 9 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03737

3738

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 3 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE Maryland — b COUNTY Wicomico
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Salisbury
d STREET ADDRESS Mahala Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First JANE Middle FRANCES Last Warden
4. DATE OF DEATH Month March Day 19 Year 1959

5 SEX Female
6. COLOR OR RACE White
7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH 12-9-1903
9 AGE (In years last birthday) 55 yrs.
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) New Jersey
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John McAleese
14. MOTHER'S MAIDEN NAME Jane Frances Lee

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
INFORMANT Address Mrs. Warden, Shaftsbury

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Acidosis, Dehydration, Coma — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Diabetes Mellitus
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19 WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 16, 1959, to March 19, 1959, that I last saw the deceased alive on March 19, 1959, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Thomas C Hill, Jr. M.D. ADDRESS (Street, city or town, state) Pine Bluff Road DATE SIGNED 3/20/59
PHYSICIAN'S NAME (Type) Salisbury, Md.

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 3-23-59
22c. NAME OF CEMETERY OR CREMATORY Our Lady of Sorrows
22d. LOCATION (City, town, or county) Seaford (State) Del

23 FUNERAL DIRECTOR'S SIGNATURE Hooker W. Marvel ADDRESS Shaftsbury, Md.
24a. REC'D BY REGISTRAR DATE MAR 26 '59
24b REGISTRAR'S SIGNATURE Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3739

CERTIFICATE OF DEATH

03738

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen Gen Hospital	d. STREET ADDRESS: Delmar Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: LOUIS	Middle: RICHARD	Last: WETZEL	4. DATE OF DEATH	Month: MARCH	Day: 16th	Year: 1959		
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐: Single	8. DATE OF BIRTH: Nov. 29, 1906	9. AGE (In years last birthday): 52 yrs	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS: Hours	Min	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee-Auto Garage-Body Repair	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Washington D.C.	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: William Henry Wetzel		14. MOTHER'S MAIDEN NAME: Catherine McCarty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W.II	16. SOCIAL SECURITY NO.	INFORMANT: Rev. Bernard F. Wetzel (Brother) — Address: 3301 Solly Ave. Phila 36, Pa.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH

434.1

DUE TO (b): Congestive Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Myocardial Failure

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that I attended the deceased from Jan, 1959, to 3/16, 1959, that I last saw the deceased alive on 3/14, 1959, and that death occurred at 9 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William B. Smith M.D. — ADDRESS (Street, city or town, state): Med Center Sby Md. — DATE SIGNED: Mar. 17/1959

PHYSICIAN'S NAME (Type): Dr. William B. Smith — Medical Center — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: Mar. 18, 1959	22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State): Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY	ADDRESS: SALISBURY MARYLAND	24a. REC'D BY REGISTRAR DATE: MAR 19 '59	24b. REGISTRAR'S SIGNATURE: Orlando L. Home	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3740

CERTIFICATE OF DEATH

03739

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 411 Mitchell St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: CANNON — Last: White

4. DATE OF DEATH: Month: March — Day: 27 — Year: 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 22, 1876

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee of County

10b. KIND OF BUSINESS OR INDUSTRY: Court House

11. BIRTHPLACE (State or foreign country): Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Elihue White

14. MOTHER'S MAIDEN NAME: Sarah Kimmey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes give war or dates of service)

16. SOCIAL SECURITY NO:

INFORMANT: Miss. Helen White-Daughter Address: 4249 Walnut St Phila. 4, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic c-v-Renal disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

DUE TO (b): Strangulated hernia c necrotic ileum — 16 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

442 X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19___, that I last saw the deceased alive on _____, 19_____, and that death occurred at 9:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William H. Fisher M.D. ADDRESS (Street, city or town, state): Salisbury Md DATE SIGNED: 3/27/59

PHYSICIAN'S NAME (Type): Dr. William H. Fisher Jr Medical Center Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 31, 1959

22c. NAME OF CEMETERY OR CREMATORY: Shad Point Cemetery

22d. LOCATION (City, town, or county) (State): R.D.# Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: MAR 31 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3741 **CERTIFICATE OF DEATH** 03740

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 30 yrs
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 603 Rose St

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R2 Salisbury
d STREET ADDRESS: 603 Rose St
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mittie — Middle: — Last: Williams
4 DATE OF DEATH: Month: 3 — Day: 10 — Year: 1959

5 SEX: Fm — 6. COLOR OR RACE: A.A. — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8 DATE OF BIRTH: 4-24-1897 — 9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): North Carolina
12 CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Paul Everett
14. MOTHER'S MAIDEN NAME: Priscilla ? Yeldela

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: NO
17 INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH: 1-2 days
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic Cardiovascular Disease ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1958, to Feb, 1959, that I last saw the deceased alive on Jan, 1959, and that death occurred at 7:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Rufus S Gardner Jr M.D. — ADDRESS (Street, city or town, state): Pinehuff Rd. — DATE SIGNED: 3/10/59
PHYSICIAN'S NAME (Type): RUFUS S. GARDNER JR. — Salisbury Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-15-59
22c NAME OF CEMETERY OR CREMATORY: Green Acre Memorial Park
22d LOCATION (City, town, or county) (State): Salisbury Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J.E. Stewart Funeral Home, Salisbury Md
24a. REC'D BY REGISTRAR DATE: MAR 17 '59
24b REGISTRAR'S SIGNATURE: Ann T. Truitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V8. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03741
Reg. Dist. No.

3742

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 614 Westover Circle

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12-614 Westover Circle Salisbury, Md.
d. STREET ADDRESS: 614 Westover Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: — Last: Wilson
4. DATE OF DEATH: Month: 3- Day: 17- Year: 19 59
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-22-11
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Wilson
14. MOTHER'S MAIDEN NAME: Ella Locker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 231-09-1551
17. INFORMANT: Harriett Ellis — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral edema — INTERVAL BETWEEN ONSET AND DEATH: Hours
600.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Uremia — Days
DUE TO
(c): Hydronephrosis-Prostatic Hypertrophy — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Earl L Royer, M.D.
DATE SIGNED: 3-19-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-22-59
22c. NAME OF CEMETERY OR CREMATORY: Berkley Cem
22d. LOCATION (City, town, or county) (State): Berkley Md

23. FUNERAL DIRECTOR'S SIGNATURE: Parker Mortuary
ADDRESS:

24a. REC'D BY REGISTRAR: DATE: APR 1 '59
24b. REGISTRAR'S SIGNATURE: Anita S. Kemp

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3743

CERTIFICATE OF DEATH

03742

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springhill Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxford
d. STREET ADDRESS: Box 116
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: William — Last: Wilson, Sr.

4. DATE OF DEATH: Month: March — Day: 25, — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-25-1871

9. AGE (In years last birthday): 88 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinest

10b. KIND OF BUSINESS OR INDUSTRY: Pumps

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Wilson

14. MOTHER'S MAIDEN NAME: Agnes Bacon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 116-09-3511

17. INFORMANT — Address: Mrs. Mary Welcker, Oxford, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): (cardio vascular renal disease) — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

442 X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-19-57, 19____, to 3-25-59, 19____, that I last saw the deceased alive on 3-27, 1957, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip A Insley M.D. — ADDRESS (Street, city or town, state): East Main St., Salisbury, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. Philip A. Insley — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 3/28/59

22c. NAME OF CEMETERY OR CREMATORY: Wm. Lee's Crematory

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salisbury, MAryland

Norman F. Baker

24a. RECEIVED BY REGISTRAR — DATE: MAR 30 1959

24b. REGISTRAR'S SIGNATURE: Arthur J. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) SM 10/57